A Report to
The Honourable A. B. R. Lawrence, M.C., Q.C.
Minister of Health

Report of the Minister's Committee of Inquiry into Hospital Privileges in Ontario

January 14, 1972

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The Honourable A. B. R. Lawrence, M.C., Q.C., M.P.P.,
Minister of Health,
Parliament Buildings,
TORONTO 2, Ontario

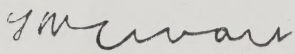
Dear Sir:

We now have the honour to submit this Report of your Committee of Inquiry into Hospital Privileges in Ontario.

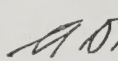
We wish, with your permission, to acknowledge the invaluable assistance of our Counsel, Mr. Julian Porter, and our Secretary, Mr. Omer H. Clusiau. They helped us not only in our researches and in the conduct of our hearings, but also in the preparation of this Report, and we are very much in their debt.

Yours very truly,

S. G. M. Grange, Q.C.,
Chairman



Hugo T. Ewart, M.D.



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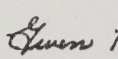
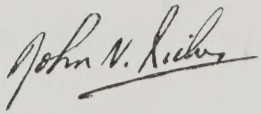


(Mrs.) Gwen Pemberton



John V. Riches, M.D.

Toronto, 14th January, 1972.

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Report of the Committee

I TERMS OF REFERENCE

Our terms of reference were taken from the Minister's statement to the Legislative Assembly on June 30th, 1971, and are as follows:

(to)

(a) *inquire into and report upon*

(i) *the appointment of medical staff and the granting of privileges to medical staff in public general hospitals;*

(ii) *the practices and methods of public general hospitals relating to the admission of patients for treatment and the priorities established for the use of hospital beds and other facilities;*

(iii) *the practices and methods of the teaching and non-teaching public general hospitals respecting the admission of patients of physicians holding staff appointments as against patients of physicians not holding such appointments, and whether inequities result under the present system.*

(b) *recommend, after due study and consideration, such changes in the laws and in the procedures and processes of the public general hospitals as in the opinion of the Committee may be requisite.*

It has not been easy to determine the precise limits of our terms of reference, but we believe that we are required to consider and report on the following matters only:

1. The appointment of doctors to hospital staffs;
2. The privileges granted to doctors on appointment;
3. The limitations, restrictions and qualifications imposed on doctors after appointment and during service;
4. Cancellation of privileges of doctors;
5. The allocation of beds in hospitals and the methods of admission and discharge of patients;
6. Special considerations concerning teaching hospitals.

In considering these matters and in the Report that follows, we have tried to be ever mindful of the Minister's request to us that the public interest should be our foremost concern.

II THE PRESENT LAW

In dealing with the matters to follow, we should bear in mind the following propositions of law, based either upon statute or common law:

1. The Board of Trustees of a hospital (sometimes called "the Board of Directors" or "the Board of Governors") has control of the affairs of the hospital and of the appointment of staff to the hospital, but there is considerable doubt that the Board has any authority to appoint a doctor to the staff of a hospital against the recommendations of the Medical Advisory Committee for such appointment. See Regulation 729, particularly section 2, ss. 6(1)(d) and ss. 6(6)(a).

2. There can be no admission to a hospital except upon the authority of a doctor of that hospital staff. See Regulation 729, section 31.

3. A hospital cannot turn away a patient requiring active treatment. See *The Public Hospitals Act*, s. 17(1). (This is a little difficult to reconcile with the above Regulation on admissions, and is also difficult to reconcile with the practice where one hospital knows that another is better equipped and directs an ambulance to that other hospital. It is recommended that this apparent legislative conflict be resolved.)

4. Where the privileges of a doctor are restricted or cancelled for misconduct or negligence or incompetence, the College of Physicians and Surgeons of Ontario must be notified pursuant to *The Public Hospitals Act,* s. 40. This is the only notification that the College receives, and it will become apparent that there are many other adverse determinations of a doctor's qualifications made by a hospital and not communicated to the College.

5. There is no right of appointment of a doctor to a hospital. This has been clearly established by the *Henderson v. Johnson* case, (1957) O.R. 627, (1959) S.C.R. 655. Certain of the dicta of Roach, J.A. in the Court of Appeal indicate that a hospital cannot arbitrarily refuse an appointment, but that point was not dealt with in the Supreme Court of Canada. It was indicated in *Regina v. Orillia Soldiers Memorial Hospital ex parte Newton,* (1971) 2 O.R. 397, that the Court would ensure that wherever a question relating to the cancellation of a doctor's privileges was involved, the rules of natural justice would apply. This principle, however, has not been extended to the initial application for privileges in a hospital. The applicant doctor has no right to a hearing, and the Courts will not review the merits of the hospital's judgment in refusing his application.

6. There is no liability in law for statements made without malice by referees, doctors consulted independently by Medical Advisory Committees, or the Medical Advisory Committees themselves, in the course of consideration of doctors' applications. In addition, there is the protection set forth in Section 10 of *The Public Hospitals Act,* which may have been enacted out of an abundance of caution. Certainly, there is a widespread fear of lawsuits in the medical profession generally.

7. A hospital may be liable for the negligence of a doctor but is not necessarily liable merely because the doctor had privileges and performed the negligent act in the hospital. The appropriate test is the control that the hospital had over the doctor and over the act complained of; and other considerations might be the failure of the hospital staff to take appropriate steps to remedy the situation where it was known that the doctor was likely to act negligently. See *Aynsley v. Toronto General Hospital*, (1968) 1 O.R. 425, (1969) 2 O.R. 829, Supreme Court of Canada, October 5, 1971, (not yet reported).

We state these propositions of law not only because we shall be making recommendations for changes, but also because we encountered a general misunderstanding, particularly with respect to items numbered 6 and 7 above, throughout the hearings. Doctors in hospitals are persuaded, falsely in our view, that there is a tremendous legal risk in either making an adverse statement about another doctor or in permitting a doctor the privileges of a hospital.

III THE PRESENT PRACTICE

(a) The Nature and Limitations of the Inquiry

We were not, and did not seek to become, a tribunal of fact. As will be seen from the appendices, we received help from many sources within and without the Province; we sought and obtained briefs from interested persons and corporations, we held hearings, both public and private, all with a view to obtaining as much relevant information as we could before we wrote this Report. Inevitably, we heard complaints concerning particular doctors and particular hospitals. We were, of course, interested in these complaints, and equally interested in the answers to the complaints which were often forthcoming from the hospitals. Lacking subpoena power, we could not, however, determine with any exactness the propriety of the complaint or the answer, but both assisted us in isolating the problems and suggesting solutions. The complaints of substance (as opposed to procedure) could be classified as follows:

(i) the non-appointment of doctors to hospitals;

(ii) the alleged protection by the Medical Advisory Committee and the medical staff of their own interests by exclusion of others from hospital privileges;

(iii) the oppression of doctors, e.g., unfair limitations against them and their patients in hospitals;

(iv) the allocation of beds and operating facilities to certain doctors and their patients in priority to others.

The question will of course be asked, "How serious is the problem?" Certainly if we view the whole population of Ontario, the number of hospitals and doctors in the Province and the complaints we received or heard about, we could only conclude that the problem is very small indeed. Expressed

numerically, of 10,000 questionnaires circulated by the Ontario Medical Association, to which response from aggrieved physicians only was stipulated, a total of 154 replies was received (in fact not all from aggrieved doctors). The Committee received less than 50 communications or briefs in the category and 22 individuals amplified their complaints by personal appearance. Only two complainants were without a hospital appointment of some kind at the time of their appearance before the Committee. In addition, however, we have had representations from doctors not themselves affected but disturbed by the plight of others. It has been evident that the problem is most acute in large metropolitan areas, and that specialists rather than general practitioners are most affected.

On the other hand we have been told that what we have heard is only the "tip of the iceberg" and that circumstances such as hospital hierarchies and medical solidarity prevented us from hearing more. Whether we consider the problem small, large, or small but potentially large, we are unanimously determined to offer solutions which will alleviate injustices to patient or doctor. We consider that the solutions are capable of implementation without seriously impairing the merits of the present system.

(b) The Act, the Regulations and the By-laws

The Act (R.S.O. 1970, chapter 378), the Regulations (R.R.O. 1970, Reg. 729) and the By-laws of the hospital, govern the procedure on first application for appointment by a doctor. The Act and Regulations are, of course, standard, and the By-laws, because of the supervision thereof by the Ontario Hospital Services Commission, and because of the standard forms developed by the Ontario Hospital Association and the Ontario Medical Association, have a degree of uniformity as well. In addition, the Canadian Council on Hospital Accreditation has provided guidelines for both standards and procedure.

Generally speaking, the procedure on appointment provides simply for an application to be investigated by the Medical Advisory Committee of the hospital or by the Credentials Committee, or both, and a recommendation made to the Board. The Board either accepts the recommendation or refers it back to the Medical Advisory Committee. In the latter event, the Medical Advisory Committee is required to reconsider and submit a further report to the Board. As noted earlier, it is not certain in law whether the Board can indefinitely decline to follow the recommendation of the Medical Advisory Committee, and the By-laws do not appear to resolve that problem.

The system works well in the ordinary case, but in the extraordinary case it is too inexact. Some of the injustices, or potential injustices, are outlined in the paragraphs that follow.

(c) The Problem of Natural Justice

At the very least, natural justice in our law gives to each of the parties to a dispute the right to be heard and the right to an impartial judge. Nothing

in the professional life of a doctor could be more important than the obtaining and maintaining of his hospital privileges, and yet the law and the system as it now exists, fails, in our opinion, to give him this minimum guarantee. The difficulties as we see them are these:

(i) The recommendations for initial privileges and for the cancellation of privileges are made by the members of the Medical Advisory Committee, who are themselves necessarily concerned in the number of doctors practising in that hospital.

(ii) Nowhere in the practice and procedure (except possibly in the cancellation of privileges—see *Regina v. Orillia, supra*) is there any requirement that the doctor concerned be heard to answer the charges against him or to state his own case.

(iii) It is implicit in the procedures laid down that each application be processed expeditiously right through to the Board of Trustees. Nowhere, however, are any time limits set forth, and the evidence was replete with examples of discouragement amounting to rejection, even before the application got to the Medical Advisory Committee.

It must be understood that by so stating we are not accusing hospitals or Medical Advisory Committees of injustice. We merely state that the possibility of avoidable injustice exists and must be removed.

(d) The Role of the Board of Trustees

As previously stated, ultimate control of the hospital lies with the Board of Trustees. It is also noted, however, that there is doubt of the legal right of the Trustees to override the Medical Advisory Committee on medical matters, and in practice it is rarely done.

It is unquestionable that the Province and the public have been extremely well served by the selfless and unrewarded efforts of the men and women who have been elected to or accepted appointments to Boards of hospitals. Nothing should be done to deter them from the continuation of these very valuable services. Indeed, it is our belief that their role should be strengthened; that they should be encouraged to act more decisively in the administration of their hospitals, and given the power and authority to do so. Our recommendations are designed to that end.

IV THE APPOINTMENT OF DOCTORS

(a) The Rights and Claims of Parties

We start with two propositions which, however desirable, are unfortunately to some extent incompatible. These are as follows:

1. A doctor should have privileges in the hospital of his community. The benefits to the doctor in the development of his skills and the widening of his practice by association with any hospital are obvious, but it is also of

immense convenience to him and his patients to be associated with the hospital of their community.

2. A hospital should have the right to decide who should be on its staff. This, too, is obvious because it gives the hospital the opportunity to create a better hospital and a better place for the care of patients.

To resolve these sometimes incompatible propositions requires us to consider the claims of all the persons and bodies concerned. The commonest cliché in both oral and written presentations made to us was that "hospitals are for patients." The proposition is, of course, unassailable, but it does not go far enough. It does not even distinguish between patients, because the interests of patients in the hospital may run counter to the interests of those patients who are prevented from getting in by the hospital policies. We believe that all of the following have certain claims to consideration, and it is our object to satisfy their claims as best we can. These claimants are:

(1) Patients, (a) in hospital; (b) in the community

(2) Doctors, (a) on staff; (b) wishing to be on staff

(3) Hospitals, including the Boards of Trustees, Administrators and all the people they represent.

Dealing with the claims of these claimants in detail, we appreciate that, like the original propositions, they are not always compatible. The claims are as follows:

(1) Patients

Patients in a hospital have a legitimate claim to the best treatment that the hospital can arrange. The people of a community have a legitimate claim to be treated in the hospital of their community, at least to the extent of the services available.

(2) Doctors

Doctors practising in the community have a legitimate claim to be able to conduct their practices in association with the hospital of the community. Certainly they have a right to natural justice and the appearance of natural justice in the process of their application to be appointed to the hospital.

Once a doctor is appointed to the staff of the hospital, he has a claim to privileges (and associated responsibilities) in the hospital commensurate with his competence and no deprivation of those privileges without just cause, and he has an arguable claim to protection by the hospital so that his skills will be maintained and possibly even so that his volume of work and income will be adequate.

(3) Hospitals

Hospitals have a right and even a duty to arrange a smooth, functional, efficient unit to best serve the needs of the community.

It will be readily seen that some of these claims are diametrically opposed to others. The claims of the hospitals and the doctors on staff and the patients within the hospital, all suggest a "closed hospital," where new doctors are admitted to staff only with great care. The interests of doctors who are not on staff but practising in the community, and, perhaps to a lesser extent, the patients of those doctors, require the appointment of those doctors to the staff of the hospital, and with each appointment, the right of the patients of that doctor to be treated by him in the hospital of the community.

(b) Open v. Closed Hospitals, The Optimum Number

As we have seen, the open hospital is desirable for doctors without appointments, and desirable for some of the patients, but in an open hospital, the hospital itself would be in danger of losing control of its standards. We have been told many times that an open hospital would create chaos, lead to more and unnecessary operations, place a stress on the facilities and reduce the efficiency of the doctors, particularly surgeons, on the staff. We have also been told that there is no numerical problem, and the market place will solve the whole problem because no doctor will remain at a hospital where there is not a good living, and no hospital will ever become, or at least remain, over-staffed. We have no real way of knowing which position is correct, and we doubt if a fair trial has been made to make possible a proper assessment.

In the Province of Quebec, regulations have recently been passed which, in effect, eliminate all question of number from the determination of vacancies on a hospital staff, but our researches indicate that the regulations have not been in force long enough to resolve the question for us. Even if the principle of numerical limitation is accepted, there are many different views held with respect to the tests for the optimum number in any particular field of practice. Certain studies have recently been made by Dr. Irial Gogan, now of the Metropolitan Toronto Hospital Planning Council, which were put before us, and suggest that the desirable number of doctors of any specialty or subspecialty, or of family practitioners, can be determined in relation to the facilities and needs of the hospital and the community it serves. It may well be that, with such studies, a range can be determined which will be of assistance in resolving disputes between doctor applicants and hospitals where the hospital maintains that its staff in the applicant's specialty is filled.

To put it negatively, we are not prepared to say that a hospital should not have control over the number of members of its staff. We do believe, however, that a hospital should not have the right to exclusive determination of the number in any category, and we say that largely because there is the inevitable suspicion of conflict of interest where the medical staff of a hospital determines the number of doctors that may have privileges at the hospital. Where a doctor seeking appointment to a hospital is informed by that hospital that there is no room for him and the decision is made by a

body composed in part of doctors engaged in that specialty and enjoying privileges in that hospital, there may reasonably remain with the applicant the suspicion that his application was refused for selfish reasons. Even if there is no justification in his suspicion, it is our view that the interests not only of the applicant but of the doctors already on staff, would be best served by a change in the system so as to eliminate any reason for such suspicion.

(c) Personality

A significant reason for rejection of an applicant doctor's application to be appointed to the staff of a hospital, though sometimes not expressed, is the man's personality. A hospital is a very intricate mechanism, and there is no doubt that an abrasive doctor on the staff could cause incalculable harm to the administration of the hospital. No one would condone the rejection of an applicant (as put by the Canadian Council on Hospital Accreditation) "on the basis of any . . . criterion lacking professional justification." We are not, however, prepared to say that in certain circumstances an applicant may not be rejected for reasons of personality which have professional justification, but, as in the optimum number problem, we do not believe the hospital should have the exclusive right of final determination, for the same suspicion of conflict exists. This, in our opinion, would be particularly so if the hospital denies an applicant privileges upon his initial application without first giving him a trial in order to assess his personality and his adaptability at first hand. At the end of that trial, the position would be different, but upon the initial application we believe the burden upon the hospital to justify its refusal should be a heavy one indeed.

(d) Incompetence, or Addiction to Drugs, Alcohol

It is very difficult to gainsay the right of a hospital to refuse privileges to a doctor if that hospital Board or its Medical Advisory Committee considers the doctor incompetent or suffering from a disability or addiction which would render him a danger to the patients. Against this, however, it must be acknowledged that it is obviously better that the doctor be practising in association with his colleagues and under control by them in a hospital atmosphere than be allowed to practise unsupervised upon his patients, with or without privileges in a hospital elsewhere. It makes no sense for a hospital to deny a doctor privileges, or to cancel privileges already obtained, upon such grounds, without further action being taken to control the doctor's practice. Similarly, it is our view that whenever there is an allegation or suspicion of incompetence on the part of a doctor in the course of his hospital duties, the matter should not be dropped until a determination has finally been made. For this purpose, therefore, we recommend that, in addition to the present requirement of notifying the College of Physicians and Surgeons whenever a doctor's privileges are curtailed for incompetence, negligence or misconduct, the College be notified whenever an initial application is rejected on these grounds. We believe that the same notification should also be given whenever an investigation is launched into

the conduct of a doctor enjoying privileges at a hospital, and the doctor resigns before the matter is determined. In such event, the College will, of course, pursue the matter in the interest of the public.

The question of conflict of interest in the determination of competence may not be so great as in the determination of number or personality, but there is a danger, and that danger should be guarded against, and our recommendations are designed to do so.

Finally, we should just mention that there are certain aspects of personal conduct of physicians which may be the concern of the profession as represented by the College of Physicians and Surgeons, and are not, in our opinion, any concern of hospital boards. Hospitals are concerned with the administration of hospitals, and are not at all concerned with the personal lives of the members of their staff when off the hospital premises, unless, of course, that conduct is reflected in the performance of their duties in the hospital itself.

(e) Insularity

The major problem in hospital appointments is found in large urban areas, particularly in Metropolitan Toronto. In our view it is most regrettable that there is not some method whereby an application for an appointment is made not to a particular hospital but to all the hospitals in the area, so that a man rejected in one can find an appointment in another within easy distance. In Hamilton, the hospitals have co-operated to establish the Hamilton District Health Council, which by association and co-operation has prevented many of the problems we see in other districts from arising in that urban area. We commend the Hamilton District Hospitals for the experiment, and can only recommend some such association for other urban districts.

In the larger urban centres, one hospital may be particularly desirable, and therefore obtain more applications than another, equally accessible to the doctor and the patients of his community. This necessarily strains the facilities of one hospital in relation to those of others. The Ontario Hospital Services Commission is charged with the "development of a balanced and integrated system" of hospitals and has encouraged and promoted the establishment of districts under regional planning in some areas, to consider, among other things, facilities of hospitals. In addition, there is the Ontario Council of Health, advising the Minister on health matters, and there has been co-operation between the Ontario Hospital Association and the Ontario Medical Association. There is also a formal liaison mechanism for co-operation between the Ontario Hospital Services Commission and the Ontario Hospital Association. As well, very valuable assistance has been given by the College of Physicians and Surgeons and the Ontario Hospital Association in the Joint Hospital Assessment Programme. We firmly recommend that somewhere in these organizations or in voluntary organizations in which the local hospitals participate, there be arranged some method of

appointment of doctors to hospitals in metropolitan areas, or indeed in all areas, on a regional or district rather than on an individual hospital basis.

(f) Proposals

If a regional approach to staff appointments comes about, it will serve greatly to reduce the problem of initial appointment. But even if it comes, and certainly until it comes, the present state of the law and procedure leaves, in our view, two major deficiencies: firstly, there is the lack of clearly defined authority in the Boards of Trustees, and perhaps partly because of that, there is the lack of any really independent consideration by the Boards of Trustees; and secondly there is the lack of an independent, impartial body to ensure that justice is done to all parties.

As we have earlier stated, we view with concern the erosion of the Board's powers. We want the Board to be involved, and not automatically confirm the decision of the Medical Advisory Committee. We recognize, however, that there might be some instances where a Board is unable or unwilling to exercise that independent judgment. Accordingly, we propose the following:

1. The Board of Trustees

The procedure for the appointment of doctors to hospital staffs should be made standard, as follows:

(a) All applicants must be referred to and considered by the Medical Advisory Committee. There should be no cursory dismissal of an application by the Administrator, Chief of Staff, or other person in authority. It is very difficult to draw the line between discouragement and rejection, but it must be made abundantly clear to all applicants and to all hospitals that the decision of appointment or not is that of the Board itself, and every applicant must be given the opportunity to take the matter to the Board. If for any reason a doctor's application is not processed forthwith in the normal way, then the applicant may take the matter directly to the Board of Trustees.

(b) The process must be complete with a recommendation to the Board of Trustees and a report to the applicant within 60 days of the initial application. It is, of course, possible that for reasons beyond the control of the Medical Advisory Committee, a recommendation for acceptance or rejection cannot be made within the period to the applicant and to the Board, but the Report must be made within the time limit even if it says only that a final recommendation cannot yet be made.

(c) If the recommendation is anything other than an acceptance of the application, the applicant shall be entitled, if he notifies the hospital within seven days of his desire, to full reasons, and to a full hearing by the Board of Trustees before the Board accepts or rejects the recommendation. In our view, it is vital that the Board not deal with

an unfavourable application until the time has passed for the applicant to request a hearing, and no such request has been received. Reasons should be delivered within seven days of the request, and the meeting should be held within 30 days of the request. In this connection, the new *Statutory Powers Procedure Act* would probably govern. The Board of Trustees would, of course, be entitled to whatever assistance it might wish from any Committee or body within the hospital, but the decision must be that of the Board and that of the Board alone, not any Committee thereof, and not dictated by the advice or direction of anyone else.

(d) The Board shall have power to override the recommendation of the Medical Advisory Committee but if it decides to reject a favourable recommendation, it may do so only if it has provided the applicant with an opportunity for a hearing.

To make the above proposal clear, we should say that we visualize the procedure as follows:

(i) The doctor requests an application form.

(ii) If the application form is not provided, then the applicant can take the matter to the Board of Trustees forthwith.

(iii) The doctor submits his application to the Administrator who refers it to the Medical Advisory Committee.

(iv) The Medical Advisory Committee (perhaps with the assistance of others) considers the application, making all necessary inquiries.

(v) The Medical Advisory Committee makes a recommendation, and the recommendation is reported to the doctor, and to the Board of Trustees (within 60 days of the making of the application).

(vi) If the recommendation is favourable, the Board disposes of the application at its next meeting. If the Board contemplates rejecting a favourable application, it may not do so without providing the doctor with an opportunity for a hearing.

(vii) If the recommendation is not favourable, the doctor, on being advised, may within seven days ask for,

(a) reasons in full;

(b) a hearing before the Board of Trustees.

(It may be that this should be taken in two steps and the doctor may have seven days after he has received the reasons to decide whether or not he wishes a hearing.)

(viii) If the doctor fails to make the request for a hearing within the stipulated time, the Board may dispose of his application at its next meeting, which must be held within two months of the report of the Medical Advisory Committee.

(ix) If the applicant requests a hearing, the matter will be proceeded with in accordance with the *Statutory Powers Procedure Act*.

(x) The Board, after the hearing, will make its decision, which, of course, will be made known to the applicant forthwith.

(xi) Either the applicant or the Medical Advisory Committee may appeal to the Hospital Appeal Board, as hereinafter set forth.

It is to be noted that the Board gets only the barest report from the Medical Advisory Committee in the event of an unfavourable recommendation. Indeed, it may be that the Board should not even be notified of an unfavourable recommendation until the time for the request by the applicant for reasons and a hearing has passed. The whole object of the procedure is to prevent the Board from pre-judging the application before the applicant has an opportunity to present his case, and to hear the case against him made by the Medical Advisory Committee.

Of course, if a doctor does not seek the hearing, the Board must know enough of the reasons for the Medical Advisory Committee's recommendation against the appointment to make an intelligent affirmation.

2. The Hospital Appeal Board

There should be a Provincial appellate body established, composed of three doctors, one legal or judicial person and, as a representative of the public, one person not a member of either of these professions, to which appeals can be taken by the rejected applicant, or indeed, by the Medical Advisory Committee, in the event that the Trustees should decide against the recommendation of the Committee. We suggest three doctors because most appeals will deal with purely medical matters, and a certain amount of medical and hospital knowledge will be essential. It may be that the Minister may wish to consult with the College of Physicians and Surgeons before making the appointments. We may say, however, that we do not believe these doctors should be representatives of any particular school of thought within the profession, or be accountable to anyone but their own consciences for their decisions. No doctor can, of course, be without views on the issues that have been presented to this Committee but our firm belief is that each case must be resolved upon its own facts and circumstances, and the resolution is not assisted when the judges come to the hearing with the fixed, polarized positions of the organizations they represent.

We recommend the legal or judicial person in order to ensure that the proper procedure was carried out before and is carried out on the appeal. If a judge is appointed, he would doubtless be chairman, and the appointment would be subject to the provisions of the recent amendment to *The Judges Act*—see now R.S.C. 1970, c. 159, ss. 36-7.

We have given long and anxious consideration to the powers to be granted to this Appeal Board, and we have come to the conclusion that the granting of decisive powers is essential. We wish to encourage the Trustees to act more independently than they have in the past, but inevitably there will be reliance upon the advice of their Medical Advisory Committees. There

can be no true impartiality without the ultimate power being with an independent body, and accordingly, we propose that the Hospital Appeal Board shall have full power to review and decide the propriety or otherwise of the initial rejection or acceptance, and shall have power to reverse the decision appealed from, to send it back to the Board for a further hearing, or to limit or extend the privileges of the doctor in question.

The Hospital Appeal Board will consider independently in each instance, wherever it is applicable, the problems of optimum number, personality and competence, mentioned earlier, and any other problem, and will also be empowered to consider the problems on a regional basis if appropriate.

We do not anticipate that the Hospital Appeal Board will be used extensively, but we think its very presence will ensure justice and the appearance of justice in the granting of privileges. We believe that the Hospital Appeal Board will take very careful consideration of the expresssed objects or criteria set up by Boards of Trustees and will not arbitrarily substitute its view for that of the Trustees. We do believe, however, that the existence of such an appellate body would eliminate suspicion of the motives of Medical Advisory Committees previously referred to, and in fact should be welcomed for that reason.

V LIMITATIONS AND RESTRICTIONS, CANCELLATION OF PRIVILEGES

It is our view that the Appeal Board could perform very readily some function whenever a doctor complains of the serious limitation or cancellation of his privileges, either upon or after appointment. Once a doctor has obtained an appointment, the Medical Advisory Committee owes him a duty not to interfere with his privileges without just cause. The College of Physicians and Surgeons has recognized this obligation and has given guidance to Medical Advisory Committees in the form of the procedure to be followed in the holding of inquiries relating to the restriction or cancellation of privileges. The difficulty, of course, is that these procedures are suggestive only, and it is our view that they should be mandatory.

We do not believe that trivial matters should be taken to the Hospital Appeal Board, and we believe that that Board should be entitled to reject such appeals without a hearing, upon the ground that the restriction is not substantial. Where, however, the restriction is substantial or the privileges are terminated or cancelled, or there is a failure to renew the privileges, we believe the following should result:

(a) The termination or cancellation should take effect immediately, for the sake of the patients.

(b) Because of the importance to the doctor, he should have the right of immediate appeal to the Hospital Appeal Board from the moment the order becomes effective. That is, if a suspension or cancellation takes effect upon the order of the Medical Advisory Committee or any other

body, a doctor should have a right of immediate appeal to the Hospital Appeal Board, if he so desires. He can, of course, take the matter first to the Board of Trustees.

We have given considerable thought to the role that the College of Physicians and Surgeons might play in this connection. The College has no statutory right to interfere in the affairs of hospitals, but it has on many occasions, on invitation, sent in fact-finding teams and has helped very often to solve or diminish medical staff problems in hospitals. The College, too, is very much concerned in the competence or decline of competence of a particular doctor. We recommend, therefore, that the Hospital Appeal Board should have the right to call upon the College for information and assistance in any particular instance, and even refer the whole matter to the College for consideration and report. This applies either to the initial application or to the substantial deprivation of privileges referred to in this paragraph. It is worth noting that the College has indicated its willingness to assist hospitals in the original assessment of privileges.

Because we have recommended in certain very serious matters a direct appeal from the Medical Advisory Committee to the Hospital Appeal Board does not mean we are in any way detracting from the authority of the Board of Trustees. Certainly the Board would be entitled at any time not only to reverse the Medical Advisory Committee, but on its own accord to cancel or restrict the privileges of a doctor, subject, of course, to the right of that doctor to take the matter to the Hospital Appeal Board in serious cases.

VI APPLICATIONS FOR ADDITIONAL PRIVILEGES

In the course of our hearings we heard complaints from doctors who claimed they were qualified for greater or more extensive privileges but were denied such privileges by the hospital, and these complaints applied to both teaching and non-teaching hospitals. Needless to say, we make no finding as to the merit of these obligations. It is our view that any doctor claiming such denial should have a right to a hearing before the Board of Trustees and in substantial matters a right to appeal from the Board to the Hospital Appeal Board.

VII ALLOCATION OF BEDS

This is a specific term of reference to us but it is surprising how little attention was paid to it in briefs or oral representations. The simple fact of the matter is that everyone agreed that hospitals must so conduct themselves that patients are admitted according to their needs, and that no other considerations such as the standing of the doctor should enter into the matter. This can only be accomplished by a vigilant and active Admission and Discharge Committee, and the full co-operation of the whole medical staff. There is no question that the establishment of these Admission and Discharge Committees in hospitals has had a very salutary effect, but it is

nevertheless always possible (and perhaps not unnatural) for these committees to concern themselves more with the admission of the patients of the Chief of Staff than those of the most recent appointee, and generally to regard the wishes of the Chief of Staff more favourably. This, of course, may work a hardship upon certain patients, based only upon the accident of their choice of physician, and we believe that a doctor against whose patients such discrimination is shown, and any of those patients, should have a remedy. If the Board of Trustees cannot, or will not, set the matter right, then the Hospital Appeal Board is available for the purpose.

VIII TEACHING HOSPITALS

Much of our time and many of the briefs received concerned teaching hospitals. The only difference for our purposes between teaching hospitals and ordinary hospitals is that a new hierarchy has been imposed in the person of the Universities which, of course also have claims to consideration, as have the students of the University. We found some difficulty in reconciling the legislation. The provisions of Regulation 726 of the Revised Regulations of Ontario (1970) would appear to indicate that only hospitals providing for the teaching of undergraduates can now be classed as Group A hospitals. Nevertheless, the schedule of Group A hospitals attached to that very regulation would seem to include certain hospitals where no such teaching function takes place.

In any event, it is sufficient in our opinion to say that where a community hospital has a teaching facility, the service to the community must be the prime consideration. Various complaints have been received from the community doctors concerning bias in favour of teachers in the hospitals. We believe that the resources of the hospital should be available to the patients of teachers and non-teachers alike, so that a uniform standard of patient care is provided. If this is not provided, it should not be tolerated. Once again, we are of the view that if the Board of Trustees cannot set the matter right, any doctor should be entitled to take a substantial complaint to the Hospital Appeal Board.

IX SUPPLEMENTARY PROPOSALS AND UNRESOLVED PROBLEMS

(a) Appointment Procedure

There are many aspects of the procedure concerning the first application for appointment that, in our view, could be improved. They are as follows:

1. Information with respect to the applicants should be more readily obtained. We believe there should be a list, preferably kept with the College of Physicians and Surgeons, of the hospital privileges hitherto enjoyed by the applicant, and that list should be available to the Medical Advisory Committee upon request. It may be that the list will involve each hospital making a return each year to the College of the doctors on staff and the privileges granted. To make this workable, some consideration might be

given to a uniformity of nomenclature, and the College might intitate such standardization.

2. There should be no reticence in the revealing of information on an applicant by referees, consultees, or the College of Physicians and Surgeons. If it is deemed necessary, there can be further statutory protection provided similar to Section 10 of *The Public Hospitals Act,* although, as indicated above, we believe that the problem is more one of education than of legislation.

3. It should be required either by statute or regulation that all applications be given widest publicity within the hospital. Not only will this ensure that all personnel of the hospital have an opportunity to comment upon the application, but it will also assist, by the publicity, in promoting the fair and open disposition of the application.

4. The College of Physicians and Surgeons has available teams to assist and advise hospitals with respect to the granting of privileges, and so far as the smaller hospitals are concerned, has recommended to us that the use of such teams be made mandatory. We are somewhat loath to recommend that a hospital do anything that will detract from the ultimate authority of the Board of Trustees, but we can certainly recommend to every hospital that requires the assistance, that it make use of the offer made by the College. No doubt the Hospital Appeal Board will be interested, in appropriate instances, in whether or not the offer was accepted and acted upon.

5. The College of Physicians and Surgeons has indicated that it may be prepared to assess the hospital privileges of physicians and surgeons, and if such action is taken, we have no doubt that hospitals would be well advised to take advantage of such assessment.

6. One of the greatest protections to patients is an annual re-assessment of a doctor's qualifications. To encourage such re-assessment, we recommend that every appointment be reviewed each year by the Medical Advisory Committee, and a recommendation made to the Board. Such practice is, indeed, a common requirement of hospital By-laws. Naturally, if there is a denial or refusal to renew, the appeal procedure becomes available to the doctor.

7. It is also a common and desirable practice to make every original appointment provisional for a prescribed period, and we have been pressed to recommend that such practice be made mandatory. We are reluctant to do so because circumstances may well exist, particularly in transfers from one hospital to another, where no probationary period is necessary. We do, however, recommend the practice as a general, but not universal, rule, to those hospitals not now carrying it out.

8. We have considered the limitations of appointment to the courtesy staff of a hospital. While advocating that every physician should have an active staff appointment at one hospital (and in some communities it would seem

he should have an active appointment at more than one) we are not prepared to recommend the elimination of the courtesy category. It has worked well in some communities, and to abolish it would, in our opinion, cause unnecessary concern. We have been presented with allegations, however, that certain doctors who are fully qualified and on the courtesy staff, and prepared to dedicate their full allegiance to one hospital, are denied the opportunity of becoming members of the active staff. In such instances we recommend that, where the Board of Trustees will not act, the matter can be taken to the Hospital Appeal Board.

(b) The College of Physicians and Surgeons

As previously indicated, we believe the College has a very important role to play in the assistance of Medical Advisory Committees, Hospital Boards and the Hospital Appeal Board. We also believe that the College has a very material concern in the granting, suspension or cancellation of privileges, insofar as it reflects upon the competence or character of the doctor concerned. Because of that, and for the reasons set forth in IV(d) above, we recommend that a hospital be required to report to the College in any of the following circumstances:

(i) When an application for privileges is rejected because of incompetence or other professional misconduct.

(ii) When privileges are suspended or cancelled or reduced for incompetence or other professional misconduct.

(iii) Whenever a hospital has commenced or threatened to commence an investigation into the conduct or competence of any doctor, and the hospital is unable to complete the investigation by reason of the resignation of the doctor from the staff. In such event, of course, the College will continue the investigation, and is already empowered to do so.

(c) Election v. Appointment of Boards of Trustees and Medical Advisory Committees

We received many representations from the advocates of election and of appointment of both the Boards and the Medical Advisory Committees. The object of election to Boards is to obtain more responsible community representation, and the object of appointment is to obtain the services of many men and women who would not undergo the electoral process, at least at the hands of the whole community. The argument in favour of election to Medical Advisory Committees is that the medical staff should determine the composition of that Committee, and the argument in favour of appointment is that the Board should be able to choose its own advisors. We might just note here that Regulation 729 in Section 6(1)(b) and (c) makes a distinction between Group A hospitals (appointment) and other hospitals (election) of a Medical Advisory Committee. We suspect that the distinction is a compromise between the two positions above described.

We have some doubt that the solution to these problems is within our terms of reference. In any event we are not prepared to offer solutions. The question is related to the total area of hospital administration, and we believe that the more limited problems we were instructed to investigate will be solved by the Hospital Appeal Board regardless of whether either body is appointed or elected.

(d) Other Disciplines

The difficulties we encountered in interpreting our terms of reference arose mainly from (a)(ii) on page 3 of this Report, where the reference to the "admission of patients" did not distinguish between patients of physicians and patients of others desiring to use hospital facilities for the treatment of patients. Accordingly, we did receive briefs and reports from dentists, podiatrists, optometrists and others asking for privileges for those disciplines in hospitals. Some of those representations concentrated upon the team approach to hospital treatment, and all of them, in our view, were very persuasive of the need for the particular service in hospitals. We are not, however, prepared to make any recommendations, for the following reasons:

(i) Initially we discouraged briefs and attendances by these other health disciplines, and accordingly we did not hear from them all.

(ii) We do not believe that the Minister intended us to duplicate the extensive work already done on the subject by the Committee on the Healing Arts.

(iii) We do not feel ourselves qualified to make a report relating to these other disciplines because neither the hospitals nor the physicians nor generally speaking the patients submitting briefs to us and appearing before us, made representations upon the problems involved, and consequently, we have not received a sufficiently balanced picture to make an intelligent report.

(e) Abortions

We also received representations from the Association for the Repeal of Canadian Abortion Laws (ARCAL) and after receiving these representations, broadened our inquiry to the extent at least of asking hospital administrators and others their views on the subject. Once again, however, we do not wish to make any report on the subject, partly because it is only peripherally related to the problems with which we are really concerned, but more because it is very much wrapped up in public policy, and decisions of that nature should, of course, be left to legislators, whether federal or provincial, in whose legislative competence the particular problem lies.

Having acknowledged our ignorance, we are perhaps bold to venture just a little further. One of the major complaints of ARCAL was the lack of information with respect to the policies and practices of a particular hos-

pital. It was said that a potential patient did not know and could not find out where and how an abortion could be performed within the law. It may be that such information could be supplied by a central provincial agency, but the difficulty seems to us to be that in some instances neither the medical staff nor the Boards of Trustees of the eligible hospitals have studied the problem sufficiently to have formed a recognizable policy. No one suggested that a policy should be forced upon a hospital, but it seemed reasonable that a hospital should make up its own mind on its policy in the matter and make known and adhere to that policy. It will, of course, take study, but we recommend that a study be made in each instance.

X SUMMARY OF RECOMMENDATIONS

We recommend that:

1. It be made clear that the Board of Trustees has overriding authority on appointment and discipline of staff, and every matter relating to the proper function of the hospital.

2. The procedure for the appointment of doctors be standardized to ensure:

(a) That the Board of Trustees not consider adverse recommendations until the applicant can appear before it and plead his cause.

(b) That the Medical Advisory Committee make a recommendation, and such recommendation be reported to the applicant and the Board within 60 days of the application first being received.

(c) That the applicant against whom anything but a favourable report is to be made have full reasons and a hearing before the Board of Trustees if he so desires.

3. A Hospital Appeal Board be established with jurisdiction:

(a) To hear appeals from the decisions of Boards of Trustees,
  (i) of rejected applicants for first appointment or renewal;
  (ii) of over-ruled Medical Advisory Committees;
  (iii) of doctors whose applications for substantially added privileges are denied;
  (iv) of doctors already on staff whose applications to become members of active staff are denied;
  (v) of interested parties complaining of substantial discrimination in the allotment of beds or the regulation of doctors and their patients within the hospital.

(b) To hear appeals of doctors whose privileges have been entirely suspended or cancelled, from the rulings of the bodies or persons effecting such suspensions or terminations.

(c) To enlist the assistance of, or refer any matter for report to, the College of Physicians and Surgeons of Ontario.

4. There be maintained province-wide records of the privileges granted to doctors, such records to be kept preferably by the College of Physicians and Surgeons and brought up to date annually by means of returns made by each hospital. (Consideration should be given to the standardization of nomenclature.)

5. There be legislative protection against defamation actions for doctors, administrators, trustees, the College of Physicians and Surgeons, and others, with respect to information given hospitals relating to applicants. (This is probably not legally necessary, but desirable for the reasons stated earlier.)

6. There be mandatory advice to the College of Physicians and Surgeons whenever,

(a) An applicant for appointment is rejected by the hospital for incompetence, negligence or misconduct.

(b) A doctor is suspended or has his privileges cancelled or seriously altered for incompetence, negligence or misconduct (this is already covered by Section 36 of *The Public Hospitals Act*).

(c) A doctor resigns voluntarily or under coercion when his competence, negligence or conduct is under investigation by the hospital.

Appendices

APPENDIX A

BRIEFS SUBMITTED TO THE COMMITTEE

1. Albany Medical Clinic
2. Alliance for Life
3. Andrew Antenna Company Ltd.
4. ARCAL
5. Armitage, Donald P., Dr.
6. Beacock, P. R., Dr.
7. Bedessee, M., Dr.
8. Berry, Diane C., Mrs.
9. Blais, S., Dr.
10. Blanchet, Gerald L., Dr.
11. Borough of North York
12. Bradley, L. O., Dr.
13. Burgess, Beverley A., Dr.
14. Central Hospital
15. Chidley, G., Mr.
16. Coelho, Philomena, Dr.
17. Cohen, Richard S., Dr.
18. College of Optometrists of Ontario
19. Consumers Association of Canada (Ontario), Health Committee
20. Corriveau, A. R., Dr.
21. Council of Faculties of Medicine of Ontario
22. Cullen, J. T., Dr.
23. Deep, Albert R., Dr.
24. De March, Leon, Mr.
25. Diesch, R., Dr.
26. Dobson, Ross A., Dr.
27. Dreyfus, Michel, Dr.
28. Erenst, M. M., Dr.
29. Essex County Medical Society (Windsor)
30. Etobicoke Medical Centre
31. Fallis, James C., Dr.
32. Ferguson, R. B., Mr.
33. Georgetown & District Memorial Hospital
34. Glass, George W., Mr.
35. Glengarry Memorial Hospital
36. Gogan, Irial, Dr.
37. Gollom, Joseph, Dr.

38. Greenglass, Esther, Professor
39. Hamilton District Health Council
40. Harris, Stephen G. C., Mr.
41. Haynes, David, Dr.
42. Heit, Murray A., Dr.
43. Hillcrest Hospital
44. James, Helen, Mrs.
45. Jory, Thomas A., Dr.
46. Joyal, Paul, Dr.
47. Kaplan, Robert P., M.P., Don Valley Riding
48. Kennedy, Frank A., Mr.
49. Khan, A. H. Mahmood, Dr.
50. Kingston General Hospital
51. Kitchener-Waterloo Hospital, Medical Staff
52. Kitching, D. C., Dr.
53. Laughton, J. S., Dr.
54. La Verendrye Hospital (Fort Frances)
55. Law, John T., Mr.
56. Leventhal, A., Dr.
57. Liswood, Sidney, Mr.
58. Lithwick, Norton H., Dr.
59. London Psychiatric Hospital
60. Loudoun, J. R., Dr.
61. Lynch, Matthew Joseph, Dr.
62. —— Raphael, S. S., Dr.
63. Macdonald, Claude, Dr.
64. Maragh, Haridath, Dr.
65. Markkanen, W., Dr.
66. Marshall, N. L., Dr.
67. Martin, David L., Mr.
68. Mayer, Joseph M., Dr.
69. McIlraith, J. B., Dr.
70. McLaughlin, Claire, Mrs.
71. McLeod, J. T., Associate Professor
72. McMaster University Medical Centre
73. McMillin, R. S., Dr.
74. Mester, Z., Dr.
75. Mirani, Ram, Dr.
76. Mohamed, John Kenneth, Dr.
77. Morley, T. P., Dr.
78. Noonan, W. E., Dr.
79. North York Branson Hospital
80. North York General Hospital, Board of Governors
81. —— Medical Advisory Board
82. —— Medical Staff Association
83. Ontario College of Art
84. Ontario Council of Administrators of Teaching Hospitals

85. Ontario Hospital Association
86. Ontario Hospital Services Commission
87. Ontario Medical Association
88. Oshawa General Hospital
89. Ottawa Civic Hospital
90. Paul, Eva, Mrs.
91. Peel Memorial Hospital
92. Percival, W. L., Dr.
93. Registered Nurses' Association of Ontario
94. Richards, R. L. S., Dr.
95. Ruddell, Carol, Mrs.
96. Sanghi, J. K., Dr.
97. Saugeen Memorial Hospital
98. Scarborough General Hospital
99. Shaver, Elsie M., Mrs.
100. Sheriton, J. E., Dr.
101. Shute, Wallace B., Dr.
102. Siegel, E. J., Dr.
103. Sifton, Clifford, Mr.
104. Sim, W. L., Mr.
105. Sir Adam Beck Chest Diseases Unit
106. Sober, Stanley, Dr.
107. Stauble, W. J., Dr.
108. St. Bernard's Convalescent Hospital
109. Strathroy Middlesex General Hospital
110. Sutherland, R. W., Dr.
111. Teskey, Luke, Jr., Dr.
112. The College of Family Physicians of Canada (Ontario Chapter)
113. The College of Physicians and Surgeons of Ontario
114. The Etobicoke General Hospital
115. The Freeport Hospital
116. The Hamilton District Health Council
117. The Homewood Sanitarium of Guelph, Ontario, Limited
118. The I.O.D.E. Hospitals (Windsor)
119. The Metropolitan General Hospital (Windsor), Board of Governors
120. —— Medical Advisory Committee
121. The Mississauga Hospital, Board of Directors
122. —— Medical Staff
123. The Ontario Dental Association
124. The Ontario Podiatry Association
125. The Royal College of Physicians and Surgeons of Canada
126. The Royal Victoria Hospital of Barrie
127. The United Church of Canada, Board of Evangelism and Social Service
128. Thomas, K., Dr.
129. University of Ottawa, Faculty of Medicine
130. —— School of Hospital Administration

131. University of Waterloo, School of Optometry
132. University of Western Ontario (London), Faculty of Dentistry
133. —— Faculty of Medicine
134. University Teaching Hospitals Association
135. Victoria Hospital Board (London)
136. Waisglass, Harry J., Mr.
137. Walkovich, Peter, Dr.
138. Wallis, Suzanne, Mrs.
139. Williams, E. S. V., Dr.
140. Williams, K. J., Dr.
141. Wilson, J. C., Dr.
142. Women for an Abortion Law Repeal Coalition (Ontario)
143. Women's Liberation Abortion Referral & Birth Control Collective
144. York-Finch General Hospital
145. MacKenzie, David J., Dr. and O'Sullivan, Paul M., Dr.

APPENDIX B

HEARINGS

Hearings in centres other than Toronto were considered by the Committee, but were not required. Arrangements made in Toronto proved satisfactory for all who wished to be heard.

Although some hearings were held in private, the majority were public and involved two sittings of the Committee, the first extending from October 22 to October 30, 1971, and the second from November 15 to November 23, 1971. All public hearings were held in the Huron Room of the Macdonald Block, Queen's Park.

WITNESSES AT PUBLIC HEARINGS
In Order of Appearance

1. Dr. John Duncan Claude Macdonald
2. Dr. L. O. Bradley
3. Dr. J. E. Sheriton
4. Mr. A. McClaskey
5. Dr. G. Leslie Watt
6. Dr. Keith Welsh
7. Mr. J. E. Robinson
8. Dr. Harry Palter
9. Dr. E. W. Wight
10. Dr. N. Kramolc
11. Dr. John Kenneth Mohamed
12. Dr. J. D. Galloway
13. Dr. Gordon S. Cameron
14. Mr. James G. Smith
15. Mr. Ray C. Walker
16. Dr. A. H. Mahmood Khan
17. Dr. J. K. Sanghi
18. Mr. R. B. Ferguson
19. Dr. Norton H. Lithwick
20. Dr. Gerald Blanchet
21. Mr. R. Kaplan
22. Dr. James McPhee
23. Dr. William Bryant
24. Dr. Donald McAulay
25. Dr. Hollister King
26. Dr. William I. Taylor
27. Dr. Wesley J. Dunn
28. Dr. A. G. Parnell
29. Dr. W. H. Feasby
30. Dr. I. D. F. Schofield
31. Mrs. Claire McLaughlin
32. Dr. J. M. Cleghorn
33. Dr. E. S. V. Williams
34. Professor J. T. McLeod
35. Dr. M. Bedessee
36. Dr. D. J. Clemow
37. Mrs. Carol Ruddell
38. Dr. E. J. Siegel
39. Dr. Stanley Sober
40. Dr. John Wilson
41. Dr. Hugh Bright
42. Dr. John Rathbun
43. Dr. W. E. Noonan
44. Dr. Paul Rekai
45. Dr. J. B. McKay

46. Mr. G. L. Johnson
47. Dr. J. R. Loudoun
48. Mr. D. M. MacIntyre
49. Dr. J. B. Neilson
50. Mr. J. D. Snedden
51. Dr. A. L. Chute
52. Dr. J. R. Evans
53. Dr. H. G. Kelly
54. Mrs. Ruth Evans
55. Mr. Gershwin
56. Mr. Frank Ogden
57. Dr. John Hamilton
58. Mr. Duncan Gordon
59. Dr. R. B. Holmes
60. Dr. A. L. Chute
61. Dr. Irwin Hilliard
62. Dr. W. J. Horsey
63. Miss Dorothy Macham
64. Dr. Irial Gogan
65. Dr. James Colquhoun
66. Dr. G. Williams
67. Dr. John N. Desmarais
68. Dr. Norman DaSylva
69. Dr. F. T. H. Porter
70. Dr. D. A. D. Milne
71. Dr. Leo Mahoney
72. Dr. J. C. C. Dawson
73. Dr. A. W. Bruce
74. Mr. W. H. Noble
75. Mr. R. Alan Hay
76. Mr. W. L. MacGregor
77. Mr. George Glover
78. Mr. Roger Slute
79. Mr. Peter Wood
80. Mrs. Suzanne Wallis
81. Mrs. Eva Paul

APPENDIX C

INTERVIEWS

ONTARIO

Ottawa	Dr. G. Myers	
Toronto	Dr. C. Borrajo	
Toronto	Miss J. Gerrard	— Resident in Hospital Administration Hospital for Sick Children
Toronto	Dr. J. Dukszta	— Queen Street Mental Health Centre
Toronto	Dr. G. Robertson	— North York General Hospital
Toronto	Mr. B. Herman	— York-Finch General Hospital
Toronto	Dr. Glen Sawyer	— Ontario Medical Association
Toronto	Dr. Z. Christopher	
Windsor	Dr. W. Percival	

QUEBEC

Montreal	Dr. A. M. Legare	— The Lake Shore General Hospital Pointe Claire, Quebec
	Dr. S. H. Knox	— The Lake Shore General Hospital Pointe Claire, Quebec
Montreal	Dr. G. Turner	
Quebec	Mr. Heward Graffety	

BRITISH COLUMBIA

Vancouver	Mr. K. R. Weaver	— Vancouver General Hospital
	Dr. L. E. Ranta	— Vancouver General Hospital
	Dr. A. J. Elliott	— Vancouver General Hospital

U.S.A.

Buffalo	Mr. Leon C. Carson	— Millard Fillmore Hospital Buffalo, New York
	Mr. Bradley	— Millard Fillmore Hospital Buffalo, New York

APPENDIX D

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